Margaret Flinter (00:00)
Recorded on location at Aspen Ideas Health in Aspen, Colorado.

Mark Masselli (00:12)
The Center for Medicare Medicaid Services provides health coverage to more than a hundred million people. what are their priorities and the goals of the new leadership?

Stephanie Carlton (00:21)
Administrator Oz and I and the rest of the team are really committed to doing things that lower the overall cost of care that are good for patients. We wanna do it in a way that improves health outcomes.

Margaret (00:33)
Our guest is CMS, deputy Administrator and Chief of Staff, Stephanie Carlton. She has a very impressive background, and both the public and the private sector. Her career began as a labor and delivery registered nurse

Stephanie (00:46)
As we come out of DOGE, and I think we are committed to being past the, what I would just say, you know, a lot of it was painful. We all had friends that were affected. but having moved past that part, and now looking towards the fun part, which is how do we modernize, how do we use technology to really better care for patients?

Margaret (01:06)
This is Conversations on Healthcare.

Mark (01:18)
Stephanie Carlton, welcome to Conversations on Healthcare.

Stephanie (01:22)
Thank you, Mark. Appreciate you having me today.

Mark (01:24)
And we're here at Aspen Ideas Health, and that's so exciting here in Colorado. And, but I think most of our audience knows about CMS. I think they'd be very interested in understanding a little better about the title of Deputy Administrator, the roles and duties. so maybe you could take a few minutes and share with our audience of the scope of the work that you're engaged in.

Stephanie (01:47)
Happy to. So, as, as Dr. Oz's deputy, and obviously Dr. Oz is the administrator of CMS. He's confirmed by the Senate, so I get to act as his deputy and the Chief of staff for the agency. we are literally the largest federal agency. we have about a $1.7 trillion budget. It's more than that if you count the tax credits that are, administered through the IRS for health insurance subsidies. so quite large, when you think about running, that large of an organization, Dr. Oz needs a lot of help and almost a body double. And so, there's, parts of my role that are working with our leadership team, helping them solve problems, helping them be successful. So, as, as far as, you know, setting priorities, we just ran a strategic planning process. I spent the last 10 years in the business world, and one of the, one of the first things you do as a new leadership group is to set the priorities and figure out what do you wanna achieve while you're, have the opportunity to lead a large organization. And so we did that as we came into to CMS. and so we sat down, Dr. Oz and I sat down with each of the leaders. we have our head of Medicare, Chris Klump. We have our head of Medicaid, drew Snyder. we have a head of our innovation center, Abe Sutton. and the head of Siah, which runs the insurance pieces of CMS, Peter Nelson, and, and, and many others in the team are our COO Kim Brandt sat down as a group and, and really went through that question. And that was a big part of my job in helping set the strategic priorities for the agency. We used a process called Objectives and Key Results or OKRs. another part of that could be doing what exactly I'm here to do in Aspen, which is telling the story of what we're trying to achieve at CMS, how we're trying to make care better for patients, how we're trying to be better stewards of taxpayer, resources. and so getting out and telling our story and, and interacting with stakeholders who we believe are really important to hear from and to interact with as we're doing our job, is another part of it. another fun part of the job is sort of chief problem solver, if you will. Great. When something gets a good, good, nurse job, I learned that right as I started my career, as Margaret knows well. and, you know, as, as things come up that are unexpected, Figured out, okay, how do we solve this? Who do we need to be involved to solve it? What's our approach? How do we get it taken care of quickly? And that's another big part of my, my day job, if you will.

Margaret (04:20)
Great. That's, that's a wonderful overview. and tells us that every day brings you lots of challenges and, lots of opportunities to, do good, in the world. You know, we like to say to all of our guests, we're not a debate program. We're really interested in hearing your views, and certainly if you're in healthcare, anywhere right now with the debate that's going on with the reconciliation bill, with what will happen to Medicaid, this is kind of front and center, at least in the frontline and primary care workers. What, what are your views on the, Medicaid bill and what kinds of challenges do you think it's gonna pose, for CMS, however things play out, what will be different? What are you concerned about? How are you preparing for that?

Stephanie (05:02)
Yeah, great set of questions. And, as I talk about a role of chief problem solver, you know, that is front and center for us at CMS, given a large part of the reforms in one big, beautiful bill, are really focused on things that we will pick up the baton, from Congress, once they pass a bill. and most of those are in Medicaid. I think about 'em in, three different areas. One is the work requirements. and as we think about work requirements, they're asking folks to really engage in, in their communities, if they're receiving benefits through the Medicaid program. And that could take several different forms. One could be getting a job, another could be volunteering in their communities. Another could be education retraining for a job that they're interested in. But the idea is how do we get people to engage with their communities? And we really believe that is something that is good for humans. It's good for us to engage with our fellow human beings. It's good for us to have a way that we demonstrate, and feel purpose in our lives. And so we think this is, a major reform in it. It's, not a new concept, to be honest. This is something that President Clinton worked with Speaker Newt Gingrich on back in the nineties to do those kinds of reforms and other, federal programs, like the welfare program or what's now called, TANF, Temporary Assistance for Needy Families. and so this is something we've seen over the last several decades, make a difference in people's lives, and we think it's something important to bring to Medicaid. So that's what I would say is the first major part of the Medicaid reforms. a second is, is something that applies both to Medicaid, and to the exchanges. The, the programs that we administer through CIO. and that's just making sure that we've got the right folks on these programs. we are committed to really delivering benefits to those who are truly eligible. But there's a lot of things that during the COVID Pandemic that we just didn't do as a government. an example of that would be asking folks to share documentation that their income level is what they say. It's, this isn't a crazy new ask. It's something that, has been part of a lot of federal programs to determine eligibility that we are restoring, to both Medicaid and, exchange subsidies as part of these reforms, just to make sure that the people who really need those programs are the ones that we are, signing up and enrolling. In fact, on the insurance side of things, when we came in in January, we noticed there was a lot of folks that were enrolling, in the marketplace exchanges that found out they were enrolled after they'd been on the plan for a year. Think about that for a second. they actually found out when IRS sent them a note saying, Hey, we need you to reconcile your income with the subsidies that you were getting. And that's something that's hard for a consumer to get surprised. And they didn't actually benefit from being on health insurance the year before that. And that's not how anyone designed those programs to work. And so we think about that is just restoring common sense to how we sign people up for those programs, because we want them to work for the people that, are truly eligible for those benefits. a third major piece is, around making sure that we target payments to providers that participate in the program. Well, through Medicaid managed care managed care companies will set up networks. They'll determine payment amounts, with providers. and then they are responsible to make sure that the networks are adequate for the people who need that care. There's more we could do to make sure that is working well, but we have a process set up for that. And then through various, changes over the years, there have been these things called state directed payments that have been added on top of that process. The goal at the beginning, you know, came from a good place, which is to say the states want to add extra payments for providers that are doing interesting things on quality. That's really how it started. Although when we started looking at the data, there's only half of the states that were complying with the quality plans that they, they were, they were committing to us to do. so it wasn't really fulfilling the quality objective. and then what happened during the Biden administration is those rates, added up to commercial rates, or they were allowed to go up to commercial rates. And states are at varying levels towards that cap called the average commercial rate. But as we sat back and looked at it and said, well, you know, these are providers who are committing, to society, to vulnerable Americans that they're gonna help with their healthcare needs. and, and we have historically paid them at Medicaid rates are often up to Medicare rates. but paying up to commercial rates kind of changes the focus of the program where it becomes more about facilities profiting, more than making sure patients are taken good care of. And so that's what we've said, Hey, we still wanna pay appropriately, but Medicare is a better cap, on those payment rates, then commercial rates. So that's really the third big area. and then Margaret, to your question, and to Mark's, what, what will CMS has to do, should Congress pass that bill? We're gonna be real busy, real soon, doing the implementation of that.

Mark (10:27)
You know, we're recording this now and, people may hear it after the bill's been passed, but the, house and Senate are still working on the legislation. We had the opportunity to talk with, Governor Sununu just a few minutes ago, listen to him and, former governor of New Hampshire Republican, and who was worried about the responsibilities that states will have financially, with the new bill. And again, it's still in the works. the Senate has a draft, the house has passed a version at this point, just worried about whether or not there's a financial capability at the state level. And I'm wondering sort of, not to get into the details of your conversations with governors, but I'm sure there's some anxiety because it seems like some of what's happening, at least in the house, in the Senate, that you'll have to administer is some real, shift of responsibility in terms of things that won't be there, in terms of reductions that the states will have to address all at once. And I'm wondering how you think that needle is going to be thread, and are you having those conversations now with states about trying to just understand what their financial responsibilities will be if the program is reduced?

Stephanie (11:50)
Yeah, absolutely. Great question. Anytime you, make changes to Medicaid, governors start asking a lot of questions, and they ask hard questions, and they're good questions that we need to be ready to answer and say. Absolutely. We've spent a lot of time talking to governors, to state health secretaries and to state Medicaid directors about the implications of this. and the implications really do depend on which part of the bill we're talking about. So on work requirements, that is something we would partner with the states on implementing. We believe that we could do that in very different ways than it's been tried before. using technology solutions that are much quicker to implement and that are much more consumer friendly to implement. but that's something we'll work in partnership with the states on…

Mark (12:38)
Is that because people have said that administrative burden might be too great for the states to manage?

Stephanie (12:44)
And that's where we say, look, it is 2025. Technology allows you to do things differently and much more quickly. And in a way that, you know, consumers use their smartphones for all kinds of things. And if we're able to develop a solution with states, with governors, that is very easy for states to get up and running, and that's much easier for consumers to use, we address those administrative burdens in a way that really achieves the intent, which is how do we get people engaging with their communities, which is, really a good thing for humans, to be doing. so that's one area. that is something that, the information technology funding, there's a lot that's available. So that wouldn't be a big new burden on the states. We actually match it at 90%, which is much higher than the match for the rest of the Medicaid program. So we don't anticipate that being, a big financial burden on the states. It's a partnership we will do with them. Second, is usually where we get questions, which is around the state directed payments that I was mentioning. and there, it, it, it's not something that, directly, some would frame it as, pushing burden back on the states. It's something that lowers the rates that go to, providers like hospitals. and so that's something that could actually bring down the state costs and is designed at lowering care and making sure that the payments that we send to providers in the Medicaid program is appropriate. And that actually reduces, the state share as well as the federal share. and so something that we think is, much more reasonable. and then same thing kind of happens on the eligibility side, when, we're asking states to be more diligent, and request the appropriate documentation for who they're signing up on the program. That's also something, when you get the right folks enrolled on the program, you're really targeting resources to those who need it most. And that's not about shifting costs to the federal or state government. That's about making sure scarce resources are targeted. but I, I will step back and make a macro point. We looked at the data, and there's a lot of the original deal, if you will, between the states and the federal government. That has changed. Where the federal government committed a certain percentage varies by states, but it's typically, it could be as low as 50%. And as, high as in the, you know, mid seventies, to states. And through various things like provider taxes, and this is usually where it comes, they're sort of backdoor gimmicks. there's some folks that would use a much stronger term like money laundering, where that that kind of a process pushes or shifts responsibility to the federal government, which is not the original deal that the federal government had with states and how we co-invest in the Medicaid program. And I think that's important just to keep in mind where we need both states and the federal government, to live up to the original bargain, if you will, on how we set, set up the structure of Medicare.

Mark (15:51)
So this is the provider tax?

Stephanie (15:52)
This is the provider tax.

Mark (15:53)
And it's never, it's not a good solution, but it's one that's been in place for a while now and looks like every state uses it to some form or another. And I think that there's some worry about how quickly that will shift down. again, I think everybody says it's, it's been a bad idea, but it's one that

Stephanie (16:13)
Kind a backdoor area.

Mark (16:14)
Backdoor area, yeah.

Stephanie (16:15)
Yeah. and, and again, they use the word money laundering, or the term money laundering has been used, you know, to describe, describe it. But it, but it does kind of backdoor get around the original intent, which was for this to be a shared program. And I think that's, that is one of the parts of the bill. And that's probably where some of the inks comes from, from governors. But it has been designed in a way so that that changes are gradual, over time. So it's not that we'd ask states to do this next year. we give them a lot of time. And at the same time, administrator Oz and I and the rest of the team are really committed to doing things that lower the overall cost of care that are good for patients. We wanna do it in a way that improves health outcomes. and then you start to manage costs. 'cause, you know, costs are just too high in this country. and we're committed to doing things that lower the cost of care while we're getting better health outcomes. And that's what is then good for federal budgets and state budgets. And we want that to occur, at the same time.

Margaret (17:16)
Great. Well, I was so glad to hear you, reference early on the, work requirement and trying to really significantly improve the process for people to verify their work requirements. Because as you probably can imagine at the front end, if that doesn't work, where people find out that they've lost Medicaid is when they arrive at their primary care provider office or the pharmacy and realize they no longer have insurance. So whatever you can do, I think, in that sector using technology and redesign will be super helpful. but I wanted to drill down to maybe a specific issue we haven't talked about yet within, your very large domain. and you are involved in workforce, in some ways. And one is through National Health Service Corps loan repayment. And I, I think we've read that you had some concerns about that process and maybe some ideas, for change. I'll say, I am a National Health Service Corps scholar alum of decades ago, but I'm glad that we have the loan repayment program through National Health Service Corps. What are your concerns and what would you like to change in that domain?

Stephanie (18:16)
Great, great question. and I will say National Health Service Corps really falls under the Assistant Secretary for health. So it's not something CMS directly involves. but I would say just at a, maybe a higher level, you know, we need folks who are committed to serving, rural underserved populations. And that's important commitment to continue. some of the provisions in the bill are aimed at how do we make sure the subsidies are doing the right thing and helping folks get trained, and get ready to serve patients. But being thoughtful about how much do we need to actually subsidize that and are we setting the right incentives up in higher education? so that we're also bringing down the cost that it takes to educate, members of the workforce who are doing really good work. And I think stepping back, that's really the intent. the specifics, I'll lead to some of my colleagues over at, at OASH.

Mark (19:15)
I think the, I think the worry was there was $125,000 cap become a doctor, in terms of loan that seemed to be low relative what the costs, are out there. but, you know, I wonder if you could, maybe just going back to CMS, and thinking about every administration who comes in reorganizes themselves. Mm. That's just the nature of the business. And right now there's a reorganization going on across the government. Can you give called DOGE at this point? But everybody has their own name for when they came in from, as I said, every new administration. How is that process going now? And are you 50% way through, a hundred percent the way through, or just at the beginning of the process of taking a hard look? 'cause you talked earlier about you sitting down, with the administrator, and thinking about strategic goals, and then there's another group who's coming in and thinking about how can we streamline the cost of government?

Stephanie (20:16)
Yeah, absolutely. Great question. and that one, I would say the majority of the work that we did with DOGE happened early on when I was still acting administrator. It took the Senate, you know, a couple months that's right to consider Dr. Oz's nomination and ultimately get him confirmed. So, thankfully I had a great team. we had John Brooks who was leading our policy work going into DOGE, and then Kim Brandt, who was our Chief Operating Officer. And the three of us spent a whole lot of time, with the, the DOGE team. I think for CMS, we were really lucky. The DOGE leads, actually had a lot of familiarity with CMS. You know, Brad Smith used to run the innovation center at CMS, and so knew the agency really well and was one of our close partners on those efforts. And as we sat back and looked at the core question, it was a challenge to us to say, okay, is everything working perfectly? Are you using every single dollar at CMS? Well, and being good stewards of every single dollar at CMS? And the answer was really no. There was a lot more that we could do. I think one of the highlights for me is we sat down and asked the career leaders at CMS, what would you do? We asked them those questions. They'd been thinking about these, you know, they didn't think everything was perfect either. And so we asked them for the ideas. They came back to us with a 30-page memo of ideas and ways that they felt like we could actually strengthen the agency and use this as a chance to tackle things that we really hadn't been able to do before. And so we came, out of, and I really do think we have done the hard parts that were asked of us during DOGE, which is looking at, you know, our contracts. We had a lot of contracts that were frankly duplicative, with other parts of CMS, some that we really didn't need, some that we just needed to target better. And we saved, you know, in the billions of dollars on contract spending in a way that didn't jeopardize our mission to serve patients on Medicare, Medicaid, and the exchanges. the people part of DOGE, obviously there was some, changes in other parts of health and human services and across the government that were, much deeper, in terms of the, the FTE cuts than they were at CMS. And that's because we took a look at the structure of CMS. We as an agency, were much more reliant on contractors than in-house staff. We had about 6,700 FTEs at CMS in-house when we started. It's a little lower than that now. post DOGE. And we had more than 40,000 contracted FTEs. Think about that. And a lot of those contracted FTEs were running very sensitive data sets for us. And it was really hard for CMS to think about changing contractors if they weren't doing the job that we wanted them to do. Their security risks, like cybersecurity risks Sure. From having contractors deal with our sensitive databases. So as we sat back and started thinking about the hard questions those asked us to consider, our answers were, we actually need to strengthen our internal CMS team, reduce reliance on contractors, and then moving forward, we're actually gonna build. And so we're thinking about, the cool parts of this, which is, how do we build our internal talent? How do we bring in more, tech experts? How do we bring in more engineers sure. That know how to build, maintain, and manage our very sensitive data sets? how do we do that in-house? And so we've actually been thinking a lot about the build phase. we kept open the CMS, offices in San Francisco, in Seattle, in New York, because we wanted to use this as places we could recruit talent, tech, talent, talent. Yeah. Yeah. Perfect. and we've actually been thinking through new models of, staffing those needs we're, some folks may not be ready to commit to a whole career in government, but they might come in, for two to four years, and really learn, serve their country. They're really good at tech. They wanna help us build these databases and do things that are really innovative. And they'll come in for four years, and then go back out into the private sector. And that's a good thing, in a good way for them to serve their country. And it's a good way for CMS to get access to different types of talent, and really start to strengthen some of our internal assets and our internal team. So as we come out of DOGE, and I think we are committed to being past the, what I would just say, a lot of it was painful. We all had friends that were affected. but having moved past that part and now looking towards the fun part, which is how do we modernize, how do we use technology to really better care for patients?

Margaret (25:11)
Great. Well, in there you've mentioned, the Center for Medicare and Medicaid Innovation for CMMI. Yes. As, we, refer to it, we're pretty familiar with it. I am not sure the public at large Yeah. Understands what CMI does. But over this, these past 15 years or so, I guess. That's been around, a lot of what people now accept as kind of norms, the Medicare Advantage plans and some of the, value-based, arrangements to try and drive improvements in care have really come out of that. And I wonder, in those strategic planning sessions you talked about when we first started, first of all, lemme say I'm glad to see CMMI is still with us. And two, what are you, what are you looking at them for in terms of, strategic priorities to deliver on, to help you achieve the goals that you and the administration have?

Stephanie (25:59)
Great questions. this is a fun podcast. Y'all know your, your stuff and ask great questions. I, I would say you're absolutely right. Save MI has been around for about 15 years. It was part of the Affordable Care Act, and it was envisioned by Congress to do two things, innovate, test ways to lower cost of care while second at least holding

steady the quality, if not improving the quality. And so those were the two missions. There's a lot of testing and, innovation that has happened over the last 15 years. and anytime there's a new administration, it's our job to take stock of what are the existing sets of models, what's working and what's not. And so as we came in, a colleague of mine, Abe Sutton, is our leader of the Innovation Center. He went through every single model and really held each model up against the original tasking from Congress of the Innovation Center, which is lower costs and improved quality holder, improve quality. and so he had to do some things that were tough. And look, some of these models were really not on track to achieve those. And if we believe that just wasn't gonna happen over the course of the model, we chose to end some of those models early. It was actually about $750 million in savings. 'cause some of those models were losing money. And, you know, this is not, shouldn't have been a surprise to folks because that was really the purpose. If, if we don't think it's gonna work, then fine. We've learned, we've tested, we need to move on and try something else. and then a few weeks ago, Abe and Dr. Oz announced our go forward plan, for the innovation center. And we do believe it's a really valuable tool to test new models, that will do those two things that were, it was tasked to do by Congress. And so Abe is really launching a new set of models. it'll be rolling those out in the coming months. but there's a whole range of things. Some models we kept. A good example of that is the cell and gene therapy model. that is something that allows states to work closely with CMMI on and really, negotiate with manufacturers on some of these high-cost drugs. And then use the power of scale to get a good deal for taxpayers and then to provide access to Medicaid programs for some of these higher cost drugs.

Mark (28:26)
And that's really the sort of most favored nation drug. Is that, or is it a little different?

(28:29)
It’s actually different. It's little bit different.

Mark (28:31)
It's a little different because I, that one I think our audience would be interested in, particularly if you look at the GLP one drugs costing 1200 here, a hundred dollars in Europe. Yes. and I'm wondering, what, where do things stand right now in terms of that program, which could bring real savings to American's pocketbooks, immediately. where, where are you in terms of, of ruling that out?

Stephanie (28:55)
Yeah, great question. We are, you, I'm sure you saw the president's executive order on this topic. and that has been, you know, really inspiring. Republicans didn't typically go after drug pricing. so he was the, you said that, I said that, you know, he was the unique Republican in the field buck in 2016 that was talking about, you know, it, it really is not okay that we pay so much more than other countries. we don't think that lowering those costs mean needs to mean we don't want innovation. 'cause we do, and we're proud of the innovation that happens in America that's lifesaving. But we don't think it's fair that Americans have to pay so much more for those drugs relative to European countries. And your data on GLP ones is spot on. where you could look at, you know, the cost in the US versus, Europe, and they're, you know, below a hundred bucks for something that, you know, is between 300 and $400. if you're looking at net prices, list prices are three times that. Right. and that's just not okay. and so the president has asked us to kick off a process with manufacturers to figure out how could we get those, prices that Americans pay much closer to most favored nation. And there's, we're in the middle of those conversations, so I can't get into details, but we've met with many of them and started to have those conversations. And there's a range of tools that we have at our disposal at CMS, that if those negotiations are not successful, that we have, you know, a set of things that we can do via regulations. but we really hope it's something that we can get a lot of manufacturers on board with. And, you know, in some of the early conversations, there's a lot of manufacturers that Agree and they, they, You know, feel like their hands are tied, in a lot of European countries because they're paying so low and it's sort of a price to just, offer drugs in those countries. And it's something that I think everybody's committed to, to rebalancing, if you will. I find myself tempted to keep going back to CMMI. It's your favorite topic.

Margaret (29:59)
Ask about all those, all those questions, because I, I do, but I'm gonna, I'm gonna hold off 'cause we have a lot of things we want to, talk to you about and, it's such a good, follow up to it. Marc asked, in terms of, people just, you know, being confronted with these enormous challenges, at least in pharmacy, when you show up at the drugstore, you know what it's gonna cost you, right? The whole issue of healthcare, pricing transparency, which I know, you're very interested in, is such a big thing for consumers. Nobody knows when they go into the emergency room and all these things are happening or into the hospital or even to the specialist office,

sometimes even primary care, what they're going to walk away with in, in terms of billing. What's the, what's the CMS goal around trying to, make healthcare pricing more transparent to consumers?

Stephanie (31:49)
Yeah, so the, we've taken some recent actions on that, that really build on a priority The president put in place in the first administration, which is using every tool at our disposal to make prices transparent to the public. and your example of, you know, consumer knows what they're gonna pay at a grocery store for things, but it's hard to really get good data on what is their care gonna actually cost them and then make good decisions. And so what we've, recently released, there's a couple parts to some, you know, starting to get at better transparency around prescription drugs. the part that CMS has really been focused on is getting the data from hospitals on actual prices. there were some things that happened over the last several years that rolled back some of the things that we did in the first administration, that made it more estimated prices. And we were like, no, we really want, the actual prices we're serious. and so we recently released some guidance on that that gets closer to actual prices. and the idea there, obviously there's a lot of data that's out there, but we want the data out there. so that those, mega files and they, they are massive files, can be accessible to consumers, but also catalyze, solutions that industry develops to actually make that much more user friendly to consumers so they can go and, compare, you know, I live in Dallas, before I came to DC a few months ago, to go and compare what, what our costs gonna be at UT Southwestern versus Baylor versus Texas Health Resources. And, that is an important start. That obviously gives you pricing data. It is also something that once the pricing data is out there, entrepreneurs can build on and start to give consumers an even more holistic understanding of value. that more holistic view of value starts to give them information on quality, information on convenience. And you start to put all of those pieces together, then patients get the information they need to say, okay, well this one's three times as expensive, but it's gonna be three months and it's 30 miles away. This one's gonna be next week, and it's maybe 20% more expensive. And here's what my copay looks like if I go there. You know, this is the best answer for me. And the vision is we want patients to be able to have that kind of information.

Mark (34:15)
Well, Stephanie, thank you so much for joining us today and for this important conversation and shining a light on the work that you're doing and also that CMS is doing. and to our audience, thank you for joining us and we, remind you, you can join us on YouTube or subscribe to us on x. Again, thank you for the time today. Thank you for having me.

Margaret (34:37)